The harm of contact and non-contact sexual abuse: health-related quality of life and mental health in a population sample of swiss adolescents

Landolt, Markus A ; Schnyder, Ulrich ; Maier, Thomas ; Mohler-Kuo, Meichun

DOI: https://doi.org/10.1159/000446810

Psychotherapy and Psychosomatics

Received: October 2, 2015
Accepted after revision: May 12, 2016
Published online: August 12, 2016

Psychother Psychosom 2016;85:320–322
DOI: 10.1159/000446810

The Harm of Contact and Non-Contact Sexual Abuse: Health-Related Quality of Life and Mental Health in a Population Sample of Swiss Adolescents

Markus A. Landolt[a, c], *Ulrich Schnyder*[b], *Thomas Maier*[e], *Meichun Mohler-Kuo*[d]

[a]Department of Psychosomatics and Psychiatry, University Children's Hospital Zurich, [b]Department of Psychiatry and Psychotherapy, University Hospital Zurich, [c]Division of Child and Adolescent Health Psychology, Department of Psychology, and [d]Epidemiology, Biostatistics and Prevention Institute, University of Zurich, Zurich, and [e]Psychiatric Services of the Canton St. Gallen-North, Wil, Switzerland

The World Health Organization [1] defines child sexual abuse (CSA) as the involvement of a minor in sexual activity that he or she does not fully understand and is unable to give informed consent to, for which the child is not developmentally prepared, that is enforced without the child's consent, or that violates the laws or social taboos of society. CSA comprises activities with actual physical contact (e.g. rape, unwanted touching) and without physical contact (e.g. exhibitionism, exposure to pornography, verbal sexual harassment, distribution of intimate pictures against one's will). Research has shown that CSA is a persistent public health problem across all countries and cultures. A global meta-analysis found mean CSA prevalence rates of 19.7% in females and 7.9% in males [2]. It is well established that CSA has negative consequences for physical and mental health that can last far into adulthood [3].

Interestingly, there is almost no research on the differential effects of the type of CSA on outcome. No epidemiological study has examined the separate and combined impact of non-contact and contact CSA on physical and mental health in adolescents. Therefore, we do not know whether non-contact types of CSA have as negative an impact as contact CSA. This is of particular importance, since the number of non-contact forms of CSA have increased in recent years with the widespread use of social media among youths [4]. To bridge these research gaps, the aim of the present study was to assess health-related quality of life (HRQoL) and mental health across contact and non-contact types of CSA in a population sample of adolescents. We expected to find an impaired HRQoL and mental health among youth with a history of any type of CSA, with larger problems being present in contact types of CSA.

We assessed a nationally representative sample of 6,751 Swiss 9th grade students (mean age 15.5 years) attending public schools. Methods of sampling and the procedure of data collection have been described in a previous publication [4]. CSA was assessed by means of the Child Sexual Abuse Questionnaire (CSAQ) [4]. Based on this measure, the subjects were classified into four mutually exclusive categories: (1) no CSA: no exposure to any type of CSA; (2) non-contact CSA only: exposure to any CSA event without physical contact; (3) contact CSA only: exposure to any CSA event with physical contact only, or (4) both types of CSA: exposure to both contact and non-contact CSA. For the current analyses, lifetime prevalence of CSA was used. Health-related quality of life was assessed by means of the well-established SF-12 Health Survey [5]. Two summary scales were calculated: the physical health component score and the mental health component score. The standardized mean is 50 (SD = 10), with higher scores indicating better HRQoL. Psychological adjustment was evaluated with the self-report version of the Strengths and Difficulties Questionnaire (SDQ), a well-validated screener measuring emotional symptoms, conduct problems, hyperactivity-inattention, and peer relationship problems [6].

Lifetime prevalence of CSA: roughly 40% of females and 17% of males reported experience of some type of CSA in their lifetimes, with 'non-contact CSA only' considerably more prevalent in both genders (24.7 and 12.1%, respectively) than 'contact CSA only' (5.1 and 2.3%) and both types of CSA (10.5 and 2.8%). The risk of females experiencing all categories of CSA was considerably higher than for males (OR = 2.37, 2.28, and 4.12, respectively). More details on specific types of CSA are reported elsewhere [4].

ANOVAs examining differences between the four groups were highly significant with regards to all outcome measures for the overall sample for boys and girls alike (table 1). Post hoc tests revealed a consistent pattern in most measures, showing that participants who had experienced both types of CSA had the lowest HRQoL and poorest mental health, whereas participants with no history of CSA had the highest scores for HRQoL as well as the best mental health. Notably, in almost all measures, participants with non-contact CSA only were significantly more impaired than participants with no history of CSA. Males had better mental HRQoL as well as less mental health problems than females across all four groups. Effect sizes were small to medium (Cohen's d, data not shown).

Taken together, our results indicate that there is a gradient association between the severity of CSA and HRQoL and mental health: youths who had experienced both contact and non-contact

KARGER

E-Mail karger@karger.com
www.karger.com/pps

0033–3190/16/0855–0320$39.50/0

Markus A. Landolt
Department of Psychosomatics and Psychiatry, University Children's Hospital Zurich
Steinwiesstrasse 75
CH–8032 Zurich (Switzerland)
E-Mail markus.landolt@kispi.uzh.ch

CSA had the worst overall mental health status. While this is in congruence with previous research [7–9], this is the first epidemiological study to clearly show that CSA with no physical contact alone may have detrimental effects. Although HRQoL and mental health were significantly more affected in victims of CSA with combined types of abuse, our findings clearly reveal that even the so-called 'less severe' non-contact types have negative associations with HRQoL and mental health. This finding was corroborated by multivariate analyses that controlled for a variety of sociodemographic risk factors (data not shown).

This study found females to report lower scores than males in most dimensions of HRQoL and mental health. However, this was not specific for victims of CSA: the same sex difference was also evident in adolescents with no history of CSA, thereby confirming epidemiological findings on mental health in adolescence that show a higher prevalence of many mental disorders in girls [10].

While our study has several strengths, including its large, nationally representative sample, sound data on different types of CSA, and standardized assessment instruments, some limitations merit note. First, the study had a cross-sectional design which limits its conclusions about causality. Second, data on CSA were based on adolescents' self-reports, making it possible for participants to under-report experiences of CSA. Third, we focused on CSA, even though other types of child maltreatment, like physical abuse, also influence a child's adjustment.

Our findings have a number of implications. First, both contact and non-contact types of CSA should be considered a significant public health problem that needs to be addressed with appropriate measures of primary, secondary, and tertiary prevention. Second, since non-contact types of CSA have a considerable negative association with mental health and HRQoL, measures addressing Internet safety and monitoring, such as the use of filtering or blocking software or public awareness campaigns, must be expanded and augmented. Also, children and adolescents need to be informed on how to protect themselves from these new forms of sexual abuse. Third, with regard to future research there is a need for replication of our findings in other population samples. Also, longitudinal studies are needed to better understand the causal mechanisms that link CSA to negative mental and physical health outcomes.

Acknowledgements

The data presented in this paper were assessed in the context of the Optimus Study. The Optimus Study was initiated and funded by the UBS Optimus Foundation (www.optimusstudy.org). We thank the adolescents who participated in this study as well as Ursula Meidert and all the research assistants who helped with the collection of data.

Disclosure Statement

All authors report no financial relationships with commercial interests.

Table 1. HRQoL and psychological adjustment by gender and type of CSA

	Total sample					Males					Females				
	no CSA (n = 4,776–4,806)	non-contact CSA only (n = 1,195–1,203)	contact CSA only (n = 230–235)	both types of CSA (n = 430–434)	F	no CSA (n = 2,850–2,888)	non-contact CSA only (n = 415–419)	contact CSA only (n = 78–80)	both types of CSA (n = 95–97)	F	no CSA (n = 1,918–1,938)	non-contact CSA only (n = 777–785)	contact CSA only (n = 152–155)	both types of CSA (n = 335–338)	F
SF-12 mental functions	49.12 (8.60)[a]	45.17 (9.86)[b]	44.16 (10.46)[b,c]	41.20 (10.74)[c]	156.27***	50.93 (7.89)[a,†]	48.32 (9.36)[b,†]	47.87 (9.90)[b,†]	46.15 (11.13)[b,†]	23.89***	46.40 (8.91)[a,†]	43.48 (9.71)[b,†]	42.25 (10.25)[b,†]	39.80 (10.21)[c,†]	60.09***
SF-12 physical functions	54.40 (5.94)[a]	53.60 (6.60)[b]	52.45 (7.81)[c]	51.82 (8.17)[c]	29.99***	54.56 (5.51)[a,†]	53.46 (6.51)[b]	53.41 (7.00)[a,b]	50.64 (9.22)[c]	17.98***	54.16 (6.51)[a,†]	53.67 (6.65)[a]	51.95 (8.17)[b]	52.15 7.83)[b]	12.17***
SDQ total difficulties score	9.63 (4.72)[a]	11.84 (4.63)[b]	12.24 (5.13)[b]	13.55 (5.03)[c]	154.31***	9.19 (4.76)[a,†]	11.36 (5.32)[b,†]	10.08 (4.63)[a,b,†]	12.82 (6.30)[c]	39.01***	10.28 (4.58)[a,†]	12.09 (4.20)[b,†]	13.34 (5.03)[c,†]	13.76 (4.60)[c]	84.12***
SDQ emotional symptoms	2.33 (2.07)[a]	3.31 (2.21)[b]	3.49 (2.46)[b]	4.09 (2.45)[c]	153.00***	1.74 (1.79)[a,†]	2.18 (1.93)[b,†]	1.86 (1.95)[a,b,†]	2.79 (2.50)[c,†]	15.97***	3.19 (2.14)[a,†]	3.92 (2.11)[b,†]	4.33 (2.28)[b,c,†]	4.45 (2.30)[c,†]	52.11***
SDQ conduct problems	2.01 (1.64)[a]	2.45 (1.77)[b]	2.61 (1.92)[b,c]	2.90 (1.97)[c]	56.99***	2.17 (1.73)[a,†]	2.95 (2.13)[b,†]	2.81 (2.01)[b]	3.57 (2.39)[c,†]	41.14***	1.78 (1.45)[a,†]	2.18 (1.48)[b,†]	2.51 (1.87)[b,c]	2.71 (1.78)[c,†]	46.87***
SDQ hyperactivity/ inattention	3.45 (2.02)[a]	4.04 (2.01)[b]	3.99 (1.95)[b]	4.35 (2.01)[b]	50.69***	3.46 (2.06)[a]	4.03 (2.12)[b]	3.54 (1.97)[a,b,†]	4.17 (2.07)[b]	12.01***	3.42 (1.95)[a]	4.04 (1.96)[b]	4.22 (1.91)[b,c,†]	4.40 (1.99)[c]	39.11***
SDQ peer relationship problems	1.86 (1.70)[a]	2.05 (1.67)[b]	2.20 (1.87)[b]	2.27 (1.79)[b]	12.55***	1.84 (1.74)[a]	2.22 (1.77)[b,†]	1.99 (1.81)[a,b]	2.38 (1.82)[b]	8.25***	1.89 (1.64)[a]	1.96 (1.62)[a,b,†]	2.31 (1.90)[b]	2.24 (1.79)[b]	6.65***

Data are presented as means (SD). *** $p < 0.0005$; subgroups with different superscript letters are significantly different ($p < 0.05$ with Scheffé's post hoc tests); † significant differences between females and males (t test, $p < 0.05$).

References

1 World Health Organization (WHO): Child Sexual Abuse. http://www.who.int/violence_injury_prevention/resources/publications/en/guidelines_chap7.pdf2015 (accessed July 28, 2015).
2 Pereda N, Guilera G, Forns M, Gomez-Benito J: The prevalence of child sexual abuse in community and student samples: a meta-analysis. Clin Psychol Rev 2009;29:328–338.
3 Trickett PK, Noll JG, Putnam FW: The impact of sexual abuse on female development: lessons from a multigenerational, longitudinal research study. Dev Psychopathol 2011;23:453–476.
4 Mohler-Kuo M, Landolt MA, Maier T, Schoenbucher V, Schnyder U: Child Sexual Abuse Revisited: A population-based cross-sectional study among Swiss adolescents. J Adolesc Health 2014;54:304–311.
5 Ware JE, Kosinski M, Keller SD: A 12-item short-form health survey – construction of scales and preliminary tests of reliability and validity. Med Care 1996;12:220–233.
6 Goodman R: Psychometric properties of the Strengths and Difficulties Questionnaire. J Am Acad Child Adolesc Psychiatry 2001;40:1337–1345.
7 Hillberg T, Hamilton-Giachritsis C, Dixon L: Review of meta-analyses on the association between child sexual abuse and adult mental health difficulties: a systematic approach. Trauma Violence Abuse 2011;12:38–48.
8 Maniglio R: The impact of child sexual abuse on health: a systematic review of reviews. Clin Psychol Rev 2009;29:647–657.
9 Irish L, Kobayashi I, Delahanty DL: Long-term physical health consequences of childhood sexual abuse: a meta-analytic review. J Pediatr Psychol 2010;35:450–461.
10 Merikangas KR, Nakamura EF, Kessler RC: Epidemiology of mental disorders in children and adolescents. Dialogues Clin Neurosci 2009;11:7–20.